□ 1630

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. COLLINS of New York) at 4 o'clock and 30 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

NATIONAL CLINICAL CARE COMMISSION ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 309) to amend the Public Health Service Act to foster more effective implementation and coordination of clinical care for people with a complex metabolic or autoimmune disease, a disease resulting from insulin deficiency or insulin resistance, or complications caused by such a disease, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 309

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Clinical Care Commission Act''.

SEC. 2. ESTABLISHMENT OF A NATIONAL CLINICAL CARE COMMISSION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following new section:

''SEC. 399V–7. NATIONAL CLINICAL CARE COMMISSION.

''(a) ESTABLISHMENT.—There is hereby established, within the Department of Health and Human Services, a National Clinical Care Commission (in this section referred to as the 'Commission') to evaluate, and recommend solutions regarding better coordination and leveraging of, programs within the Department and other Federal agencies that relate in any way to supporting appropriate clinical care (such as any interactions between physicians and other health care providers and their patients related to treatment and care management) for individuals with—

''(1) one or more complex metabolic or autoimmune diseases;

''(2) one or more diseases resulting from insulin deficiency or insulin resistance; or

''(3) complications caused by one or more of any of such diseases.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Commission shall be composed of the following voting members:

''(A) The heads (or their designees) of the following Federal agencies and departments:

''(i) The Centers for Medicare & Medicaid Services.

''(ii) The Agency for Healthcare Research and Quality.

''(iii) The Centers for Disease Control and Prevention.

''(iv) The Indian Health Service.

''(v) The Department of Veterans Affairs.

''(vi) The National Institutes of Health.

''(vii) The Food and Drug Administration.

''(viii) The Health Resources and Services Administration.

''(ix) The Department of Defense.

''(B) Twelve additional voting members appointed under paragraph (2).

''(C) Such additional voting members as may be appointed by the Secretary, at the Secretary's discretion, from among the heads (or their designees) of governmental or nongovernmental entities that impact clinical care of individuals with any of the diseases and complications described in subsection (a).

''(2) ADDITIONAL MEMBERS.—The Commission shall include additional voting members appointed by the Secretary, in consultation with national medical societies and patient advocacy organizations with expertise in the care and epidemiology of any of the diseases and complications described in subsection (a), including one or more such members from each of the following categories:

''(A) Clinical endocrinologists.

''(B) Physician specialties (other than as described in subparagraph (A)) that play a role in diseases and complications described in subsection (a), such as cardiologists, nephrologists, and eye care professionals.

''(C) Primary care physicians.

''(D) Non-physician health care professionals, such as certified diabetes educators, registered dieticians and nutrition professionals, nurses, nurse practitioners, physician assistants.

''(E) Patient advocates.

''(F) National experts in the duties listed under subsection (c).

''(G) Health care providers furnishing services to a patient population that consists of a high percentage (as specified by the Secretary) of individuals who are enrolled in a State plan under title XIX of the Social Security Act or who are not covered under a health plan or health insurance coverage.

''(3) CHAIRPERSON.—The voting members of the Commission shall select a chairperson from the members appointed under paragraph (2) from the category under paragraph (2)(A).

''(4) MEETINGS.—The Commission shall meet at least twice, and not more than 4 times, a year.

''(5) BOARD TERMS.—Members of the Commission appointed pursuant to subparagraph (B) or (C) of paragraph (1), including the chairperson, shall serve for a 3-year term. A vacancy on the Commission shall be filled in the same manner as the original appointments.

''(c) DUTIES.—The Commission shall—

''(1) evaluate programs of the Department of Health and Human Services regarding the utilization of diabetes screening benefits, annual wellness visits, and other preventive health benefits that may reduce the incidence of the diseases and complications described in subsection (a), including identifying problems regarding such utilization and related data collection mechanisms and make recommendations;

''(2) identify current activities and critical gaps in Federal efforts to support clinicians in providing integrated, high-quality care to individuals with any of the diseases and complications described in subsection (a);

''(3) make recommendations regarding the coordination of clinically based activities that are being supported by the Federal Government with respect to the diseases and complications described in subsection (a);

''(4) make recommendations regarding the development and coordination of federally funded clinical practice support tools for physicians and other health care professionals in caring for and managing the care of individuals with any of the diseases and complications described in subsection (a), specifically with regard to implementation of new treatments and technologies;

''(5) evaluate programs described in subsection (a) that are in existence as of the date of the enactment of this section and determine if such programs are meeting the needs identified in paragraph (2) and, if such programs are determined as not meeting such needs, recommend programs that would be more appropriate;

''(6) recommend, with respect to the diseases and complications described in subsection (a), clinical pathways for new technologies and treatments, including future data collection activities, that may be developed and then used to evaluate—

''(A) various care models and methods; and

''(B) the impact of such models and methods on quality of care as measured by appropriate care parameters (such as A1C, blood pressure, and cholesterol levels);

''(7) evaluate and expand education and awareness activities provided to physicians and other health care professionals regarding clinical practices for the prevention and treatment of the diseases and complications described in subsection (a);

''(8) review and recommend appropriate methods for outreach and dissemination of educational resources that—

''(A) address the diseases and complications described in subsection (a);

''(B) are funded by the Federal Government; and

''(C) are intended for health care professionals and the public; and

''(9) carry out other activities, such as activities relating to the areas of public health and nutrition, that the Commission deems appropriate with respect to the diseases and complications described in subsection (a).

''(d) OPERATING PLAN.—

''(1) INITIAL PLAN.—Not later than 90 days after its first meeting, the Commission shall submit to the Secretary and the Congress an operating plan for carrying out the activities of the Commission as described in subsection (c). Such operating plan may include—

''(A) a list of specific activities that the Commission plans to conduct for purposes of carrying out the duties described in each of the paragraphs in subsection (c);

''(B) a plan for completing the activities;

''(C) a list of members of the Commission and other individuals who are not members of the Commission who will need to be involved to conduct such activities;

''(D) an explanation of Federal agency involvement and coordination needed to conduct such activities;

''(E) a budget for conducting such activities;

''(F) a plan for evaluating the value and potential impact of the Commission's work and recommendations, including the possible continuation of the Commission for the purposes of overseeing their implementation; and

''(G) other information that the Commission deems appropriate.

''(2) UPDATES.—The Commission shall periodically update the operating plan under paragraph (1) and submit such updates to the Secretary and the Congress.

''(e) FINAL REPORT.—By not later than 3 years after the date of the Commission's first meeting, the Commission shall submit to the Secretary and the Congress a final report containing all of the findings and recommendations required by this section. Not later than 120 days after the submission of the final report, the Secretary shall review the plan required by subsection (d)(1)(F) and

submit to the Congress a recommendation on whether the Commission should be reauthorized to operate after fiscal year 2021.

''(f) SUNSET.—The Commission shall terminate 120 days after submitting its final report, but not later than the end of fiscal year 2021.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. BURGESS).

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 309, the National Clinical Care Commission Act, introduced by Representative PETE OLSON and which was supported by over 229 cosponsors in the 114th Congress.

H.R. 309 establishes a clinical care commission to evaluate and recommend solutions regarding better coordinating and leveraging of Federal programs related to complex metabolic or autoimmune disorders, such as diabetes.

Metabolic disorders take a large toll on many Americans each year, and complications from these disorders can lead to catastrophic health outcomes. Currently, there are various programs across the Federal Government that touch on metabolic disorders—some focus on prevention and others focus on treatment—but there is a lack of coordination among these programs. Improving coordination of such efforts provides an opportunity to reduce costs while improving health outcomes.

This legislation received broad support from the Energy and Commerce Committee, passing through a full committee markup by a voice vote during the 114th Congress.

H.R. 309 provides no new spending and utilizes only existing funds at the Department of Health and Human Services.

Mr. Speaker, I urge my colleagues to support this legislation, and I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

I rise in support of H.R. 309, sponsored by my Texas neighbor, Congressman PETE OLSON, and our other colleague on the Energy and Commerce Committee, DAVID LOEBSACK of Iowa, the National Clinical Care Commission Act.

This legislation aims to improve Federal efforts to treat and prevent metabolic disorders, autoimmune diseases, and diseases resulting from insulin deficiency or insulin resistance.

The most common metabolic disorder in the U.S. is diabetes, which affects more than 29 million Americans. Racial and ethnic minority communities suffer increased rates of this condition. 15.9 percent of American Indians and Alaskan Natives, 13.2 percent of non-Hispanic Blacks, and 12.8 percent of Hispanics have diagnosed diabetes, compared to just 7.6 percent of non-Hispanic Whites.

Diabetes takes a huge toll on human health. It is the seventh leading cause of death in the United States. Additionally, all too often, diabetes leads to avoidable complications such as blindness, limb amputation, and kidney failure.

In addition to the effects on human health, diabetes care makes up a large percentage of U.S. healthcare expenditures. Currently, $1 of every $5 of healthcare costs is spent on caring for people with diabetes. The proportion of Medicare funding is even greater. Currently, $1 of every $3 of Medicare expenditures is spent caring for people with diabetes.

That is why it is important to improve Federal efforts that prevent avoidable cases of diabetes and metabolic disorders and ensure all Americans have treatment and management of services necessary to successfully manage this and other of these conditions.

I am glad to see this legislation move forward, and I urge my colleagues to vote ''yes'' on H.R. 309.

I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. OLSON).

Mr. OLSON. Mr. Speaker, I thank the gentleman from Denton, Texas (Mr. BURGESS) for yielding me time to speak about my bill, H.R. 309, the National Clinical Care Commission Act, a bipartisan bill that received unanimous support in the last Congress and was cosponsored by over half of my House colleagues.

It had this level of support because our Nation faces an epidemic. Diabetes or prediabetes affects over 100 million Americans. Nearly one in three of our neighbors is affected. This is in addition to all of the Americans whose diseases fall under complex metabolic, autoimmune, or insulin-resistant diseases.

When I first came to Congress in 2009, it was crystal clear that we had a big problem. The benefits of all the Federal research dollars going into these diseases were simply not making their way to patients. Researchers at the NIH, the CDC, the FDA, and even DOD weren't sharing diabetes research.

It was clear to me in 2009, and it is clear today in 2017, that we need a laser-like focus on improving patient care by pursuing a strong Federal focus on research.

My bill accomplishes that goal by creating a national clinical care commission comprised of doctors who specialize in diabetes care for patients. This commission will have 3 years to strengthen their partnership between Federal stakeholders and health professionals, who will bring hands-on clinical experience to improve care.

This is not a new, unending bureaucracy. After 3 years, this commission will sunset. In 3 years, it will be gone.

We have already made a huge investment of taxpayer dollars into research. It is time for us to leverage that investment and translate that into meaningful prevention and effective treatment options.

So today, I ask my colleagues to again help those who suffer from diabetes or other complex metabolic and autoimmune disorders by voting for H.R. 309.

Mr. GENE GREEN of Texas. Mr. Speaker, I have no other speakers.

I reserve the balance of my time in case someone shows up.

Mr. BURGESS. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. CARTER), a new member of the Energy and Commerce Committee.

Mr. CARTER of Georgia. Mr. Speaker, I rise today in support of H.R. 1192, the National Diabetes Clinical Care Commission Act, which establishes within the Department of Health and Human Services the national diabetes clinical care commission.

The commission will look into dissemination of information and resources to clinicians on best practices for delivering high-quality care and how best to effectively deploy new and emerging treatments and technologies.

As a pharmacist, I play an important role in diabetes care by screening patients who had a high risk for diabetes and educating patients to empower them to take better care of themselves. I believe all of my colleagues would agree that making government work to help evaluate and recommend solutions regarding diabetes is important.

The American Diabetes Association reports that there are almost 30 million people living with this disease. With better coordination and leveraging of Federal programs that relate to clinical care for people with diabetes and chronic diseases and conditions caused by diabetes, we will begin to stem the tide of this awful disease.

This legislation should be a priority for our country, and I urge my colleagues to support this bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I want to welcome the gentleman from Georgia (Mr. CARTER) to the Energy and Commerce Committee.

I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, I have no additional speakers at this time.

This is a good bill. It did pass at the end of last Congress. Maybe by passing at the beginning of this Congress, we will give the other body ample time to take it up this year.

It is a good bill. It is worthy of our consideration again today. It provides no new spending.

I urge passage of H.R. 309.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, H.R. 309.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

IMPROVING ACCESS TO MATERNITY CARE ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 315) to amend the Public Health Service Act to distribute maternity care health professionals to health professional shortage areas identified as in need of maternity care health services.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 315

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Access to Maternity Care Act''.

SEC. 2. MATERNITY CARE HEALTH PROFESSIONAL TARGET AREAS.

Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended by adding at the end the following new subsection:

''(k)(1) The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall identify, based on the data collected under paragraph (3), maternity care health professional target areas that satisfy the criteria described in paragraph (2) for purposes of, in connection with receipt of assistance under this title, assigning to such identified areas maternity care health professionals who, without application of this subsection, would otherwise be eligible for such assistance. The Secretary shall distribute maternity care health professionals within health professional shortage areas using the maternity care health professional target areas so identified.

''(2) For purposes of paragraph (1), the Secretary shall establish criteria for maternity care health professional target areas that identify geographic areas within health professional shortage areas that have a shortage of maternity care health professionals.

''(3) For purposes of this subsection, the Secretary shall collect and publish in the Federal Register data comparing the availability and need of maternity care health services in health professional shortage areas and in areas within such health professional shortage areas.

''(4) In carrying out paragraph (1), the Secretary shall seek input from relevant provider organizations, including medical societies, organizations representing medical facilities, and other organizations with expertise in maternity care.

''(5) For purposes of this subsection, the term 'full scope maternity care health services' includes during labor care, birthing, prenatal care, and postpartum care.

''(6) Nothing in this subsection shall be construed as—

''(A) requiring the identification of a maternity care health professional target area in an area not otherwise already designated as a health professional shortage area; or

''(B) affecting the types of health professionals, without application of this subsection, otherwise eligible for assistance, including a loan repayment or scholarship, pursuant to the application of this section.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. BURGESS).

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and to insert extraneous material in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 315, the Improving Access to Maternity Care Act, which I introduced with Representative ESHOO.

H.R. 315 increases data collection by the Department of Health and Human Services to help better place maternity care providers through the National Health Service Corps repayment program. Currently, maternity care providers participate in the National Health Service Corps through the primary care designation, but they are not always placed where they are needed the most. H.R. 315 will require increased data collection on maternity care providers who will then be placed in geographic areas within existing health professional shortage areas, again, where they are most needed.

This legislation enjoyed broad support on the Energy and Commerce Committee, passing through the full committee markup by a voice vote in the 114th Congress.

H.R. 315 provides no new spending, Mr. Speaker.

I urge all my colleagues to support this legislation.

I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 315, the Improving Access to Maternity Care Act.

This important legislation would require the Health Resources and Services Administration to better identify areas with increased need for maternity care services. This would help ensure the placement of maternity care providers within the National Health Service Corps in areas with the most need for their services.

Improving access to maternity care providers in our most underserved communities will help reduce the poor health outcomes that can result when women don't have access to quality, prenatal maternity services that they need. Those outcomes can include increased infant mortality, preterm births, low birth weight infants, and maternal mortality.

To provide just one example of how limited access to quality maternity care service is affecting American communities is that while global maternal mortality rates have fallen by more than a third from 2000 to 2015, the maternal mortality rate in the United States has increased. In 2015, 25 women lost their lives during pregnancy or childbirth per 100,000 births in the U.S., compared to 23 women who did so in only 2000.

It is clear that we must do more to reverse the troubling trend and other poor outcomes that result in limited access to maternity care providers. Congress must make it a priority to ensure our women have access to prenatal and maternity care services.

I support H.R. 315. I urge my colleagues to vote ''yes.''

I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield 3 minutes to the gentleman from Tennessee (Mr. ROE), the chairman of the Veterans' Affairs Committee and a fellow OB/GYN.

□ 1645

Mr. ROE of Tennessee. Mr. Speaker, I rise today in support of H.R. 315, the Improving Access to Maternity Care Act, sponsored by the gentleman from Texas (Mr. BURGESS), a fellow OB/GYN and chairman of the Health Caucus.

One of the easiest ways to ensure a safer and healthier pregnancy experience for both mother and child is through adequate maternity care. Unfortunately, there are pockets across the United States where women do not have access to needed OB/GYN care, which puts both mothers and babies at risk should a complication arise.

As an OB/GYN who spent 31 years in practice, I find it unacceptable that 1 million babies are born to mothers who did not receive adequate prenatal care. Without that proper care, babies born to these mothers are three times more likely to be born at a low birth weight and five times more likely to die than babies whose mothers did receive adequate maternity care.

With a large number of OB/GYNs nearing retirement age and a female population expected to increase by 36 percent by 2050, there is no more important time than now to ensure adequate access to maternity care for all mothers, no matter where they live. A woman living in rural east Tennessee or rural Texas should have the same access to adequate maternity care as someone living in the city of Nashville, Memphis, Dallas, or wherever.

I am a proud cosponsor of this legislation that would require the Health Resources and Services Administration to designate maternity healthcare professional shortage areas and target maternity care resources where they are most needed, helping to ensure healthier pregnancies and healthier babies.

It was my job as an OB/GYN to make sure that mothers and their children